Third Coast Emergency Physicians, P.A. *and* Seton Third Coast Emergency Physicians Association, Petitioner. Case 16–RC–10160

February 29, 2000

DECISION ON REVIEW AND ORDER

BY CHAIRMAN TRUESDALE AND MEMBERS FOX AND LIEBMAN

The National Labor Relations Board has delegated its authority in this proceeding to a three-member panel, which has considered the Employer's request for review of the Acting Regional Director's Decision and Order (relevant portions of which are attached as an appendix). The Employer's request for review is granted.

Having carefully reviewed the record testimony, we affirm the Acting Regional Director's findings that the emergency physicians are not statutory supervisors[1] and that the emergency physicians on the senior advisory council are neither statutory supervisors nor managerial employees for the reasons stated by the Acting Regional Director, with the exceptions set forth below. Further, we agree with the Acting Regional Director that Dr. Calomeni is not a statutory supervisor and find that he is not a managerial employee.[2]

In finding that the physicians at issue do not make effective recommendations with regard to hiring, discipline, or evaluations, and that they do not formulate and implement management policy, the Acting Regional Director reasoned, inter alia, that the ultimate decision-making authority in these areas is retained by the two medical directors rather than the physicians. We agree with the Employer that the retention of ultimate authority by the medical directors does not, by itself, preclude a finding of supervisory or managerial status, but we find that, in each of these areas, as the Acting Regional Director also found, the evidence is insufficient to establish that the recommendations of the physicians are effective or that the physicians formulate and effectuate management policy. Thus, for example, there is no evidence that any recommendation by staff physicians was effective in determining particular disciplinary action. The evidence failed to show what role, if any, was played by any vote by the senior advisory council regarding hiring. There was no evidence regarding the details of removals or the role of recommendations by the senior advisory council regarding terminations. Evaluations of physicians are based on observation and participation of the medical directors and input from the hospital staff in addition to senior advisory council input. With regard to formulating and effectuating policy, the evidence fails to show that the senior advisory council takes direct action or instructs others to do so and/or the extent to which their recommendations are followed. *Montefiore Hospital & Medical Center,* 261 NLRB 569, 571 (1982); cf. *FHP*, 274 NLRB 1141, 1143 (1985).

The Acting Regional Director did not address the Employer's claim that Dr. Calomeni is a manager and/or supervisor with respect to his involvement in the complaint categorization system. In support of this claim, the Employer asserts that Dr. Calomeni promulgated and effectuated a complaint categorization system and directed and assigned an employee in developing and implementing the system. We find that the evidence fails to show the extent to which Dr. Calomeni's input into the promulgation of the complaint categorization system may have resulted in effective formulation and effectuation of policy, particularly in view of the participation of the medical directors in the process. With respect to the Employer's claim that Dr. Calomeni exercises supervisory authority, the evidence fails to show that Dr. Calomeni assigned employee Sprinkle to work on the complaint categorization system or that any direction given by Dr. Calomeni was other than routine. We therefore find no merit in these contentions.

Based on the foregoing, we conclude that the Employer has not established that any of the disputed individuals are supervisors within the meaning of Section 2(11) of the Act or are managerial employees as the Board defines that term.

ORDER

The Acting Regional Director's Decision is affirmed.

APPENDIX

DECISION AND DIRECTION OF ELECTION

The Petitioner seeks to represent all emergency physicians who perform emergency services on behalf of the Employer at Seton Medical Center and Seton Northwest Hospital in Austin, Texas. The Employer asserts these emergency physicians are supervisors as defined by Section 2(11) of the Act and thus would not properly form an appropriate unit for the purposes of collective bargaining. The Employer takes the position that if such physician employees are found not to be statutory supervisors, the proposed unit should include all emergency physicians who work at hospitals serviced by the Employer in Austin, Kerrville, and Burnet, Texas. The Employer also urges that all mid-level provider employees located at the above-described hospital locations be included within the proposed unit. There

[1] We agree with the Acting Regional Director that a government requirement that mid-level practitioners be supervised by a supervising physician does not establish that the Employer's emergency room physicians meet 2(11) supervisory requirements. However, we do not rely on *Air Transit*, 271 NLRB 1108 (1984), cited by the Acting Regional Director, as it pertained to independent contractor, not supervisory, status.

[2] The Acting Regional Director also found that the Employer, Third Coast Emergency Physicians-Sid Peterson, and Third Coast Emergency Physicians-Highland Lakes constitute a single employer that is engaged in interstate commerce within the meaning of the Act, that the Petitioner is a labor organization within the meaning of the Act, that the appropriate unit encompasses the emergency physicians only at the hospitals in Austin, and that the nurse practitioners and physician assistants are not properly included in the appropriate unit. The Employer does not request review of these findings.

are approximately 20 employees in the unit sought by the Petitioner and approximately 39 employees in the unit urged by the Employer.

Under its entire network, the Employer provides emergency physicians to nine different hospitals in seven different cities. For each city or hospital system, the Employer operates as a separate entity. There are four hospital facilities and three entities involved in this proceeding. Third Coast Emergency Physicians provides emergency physicians for Seton Medical Center and Seton Northwest Hospitals in Austin, Texas. Third Coast Emergency Physicians-Highland Lakes provides emergency physicians for Highland Lakes Hospital in Burnet, Texas. Third Coast Emergency Physicians-Sid Peterson provides emergency physicians for Sid Peterson Hospital in Kerrville, Texas. There are 20 emergency physicians and 7 midlevel providers employed by the Employer at the Austin hospital locations.

Drs. Moskow and Roberts have controlling interests in all three Third Coast corporate entities. Dr. Patrick Crocker is listed as an additional officer for Third Coast Emergency Physicians-Highland Lakes. Dr. Moskow is the medical director at Seton Northwest Hospital and Roberts holds the same position at Seton Medical Center. As medical director, Moskow interacts with Seton Northwest regarding any of its concerns and sits on the hospital's medical executive committee. Both Drs. Moskow and Roberts work some clinical shifts with other emergency physicians at both Austin hospitals.

The emergency physicians who work out of the hospitals in Austin and Kerrville are paid based on a percentage of their gross billings. The record reflects that the medical director can unilaterally alter their percentages at any time. The record also reflects that the percentage paid to the Austin physicians is higher than the percentage paid to the Kerrville physicians. In its brief, the Employer asserts that the percentage difference between the two hospitals is only 1.2 percent. Although the Employer takes the position that the parties agreed to hold the hearing open until it could substantiate its claim, the record does not reflect that the hearing was being held open for such purposes and I therefore do not rely on this evidence for the purposes of this proceeding. The physicians who work at the hospital in Burnet are paid $70 an hour. All physicians are eligible for bonuses that are determined by the medical director based on factors such as activities engaged in on behalf of the Employer, activities that have benefited a respective hospital, national committee memberships, and how profitable the Employer has been for a respective year.

Emergency physicians at all four locations are eligible for the same employee benefits pursuant to the same cafeteria plan offered by the Employer. The Employer also applies the same pension and disability plans to all emergency physicians. Any changes made to the pension plan by the Employer results in all emergency room physicians being affected irrespective of their hospital location. The same insurance company is utilized by the Employer for all four hospitals for the provision of health benefits. The physicians who work at the Austin hospitals work 10-hour shifts. The physicians in Burnet and Kerrville work 12-hour shifts and sometimes 24-hour shifts on weekends.

All potential patients who seek emergency services at any of the four hospitals must first go through the main emergency room for an initial screening. In this main room, a prospective patient is examined by a nurse and sent to either the main emergency room or the minor emergency clinic, depending on the extent of the medical care required and the hospital protocols set up for the nurse to follow. In all emergency rooms, emergency physicians give medical orders to hospital staff such as nurses, clerks, and technicians regarding the medical care of patients. This staff is employed by the respective hospital, not the Employer. All mid-level providers work in minor emergency rooms separate from the main emergency room. Although not physicians, mid-level providers are required to have medical training and education. Emergency physicians interact with midlevel providers regarding issues associated with patient medical care. This interaction may include the physician reading and analyzing X-rays taken by a midlevel provider, the physician reviewing and analyzing medical charts of patients seen by midlevel providers, and/or the physician generally overseeing that the midlevel provider has provided patients with adequate medical care.

There are certain Federal guidelines that a physician must follow regarding what must be included on a patient chart. Physicians review charts prepared by midlevel providers to ensure the documentation is within these Federal guidelines. During a midlevel provider's 6-month probationary period, emergency physicians see every patient handled by the midlevel provider. Once a midlevel provider has completed his or her probation, emergency physician contact is reduced but may still include instances of X-ray review, narcotic prescription approval, and assistance for medical situations outside their limited protocols. The record reflects that midlevel providers leave their charts with the emergency physician after they see patients and the emergency physician eventually reviews and signs them. Emergency physicians are paid a stipend for each midlevel provider chart they sign.

In order for midlevel providers to have separate prescriptive authority, the State of Texas requires each supervising physician to sign an affidavit certifying they are familiar with protocols and standing orders in use at the hospital site where the midlevel provider is located. This document holds all emergency physicians accountable for adequately supervising the care provided by a respective midlevel provider pursuant to those protocols or standing orders. Emergency physicians at hospitals in Burnet and Kerrville do not sign the prescriptive authority form for midlevel providers working out of the Austin hospitals and the Austin physicians do not sign similar forms for midlevel providers at the respective Kerrville and Burnet locations.

The record reflects that the same employee handbook is applied to all emergency physicians. The medical director may alter the handbook at any time. Regarding employee discipline, the record reflects the medical director has the sole authority to determine employee punishment after the first and second infractions and the probationary period for any additional infractions. The record reveals that emergency physicians do not have the authority to hire, fire, transfer, suspend, layoff, recall, assign, reward, or discipline midlevel providers or other physicians.

The record reflects emergency physicians provide feedback to medical directors regarding the work performance of midlevel providers and the medical director uses that information to determine how many shifts to give the midlevel provider, what monetary rewards to give these employees, and whether to continue the midlevel provider on a part-time or full-time basis. Medical directors retain ultimate authority to hire, fire, or discipline midlevel providers and are responsible for setting their

probation periods. Medical directors also have ultimate authority to extend midlevel provider probation dates.

Emergency physicians who have over 6 years of experience are eligible to participate on the employer's senior advisory council. The senior advisory council was created to provide a forum for senior physicians to discuss issues regarding physician scheduling, hiring, and retention. The senior advisory council is currently comprised of nine emergency physicians and two medical directors (Moskow and Roberts). The record reflects that the senior advisory council has only met three or four times in the last 4 years and has met only once in the past year. The record also reflects that senior advisory council meeting times are subject to approval by the medical directors.

Pursuant to operation guidelines created by Dr. Moskow, two senior council physicians are encouraged to be present during employee hiring interviews. The evidence reflects that the emergency physicians who attend these interviews ask questions and fill out recommendation forms after the interviews are completed. Regarding physician evaluations, the record reflects that senior council members fill out a form with 10 questions that ask senior council members to rank a physician on a scale of one to five on various patient care issues. The medical directors have final say on the evaluations based on their observations of the physician. The record also reflects that the medical directors seek input for physician evaluations from hospital staff. Regarding physician retention, the record reflects two instances where the senior advisory council recommended the removal of a physician and that those physician were subsequently removed from their position by the medical director. Operation guidelines provide that the medical director will give great consideration to the senior advisory council's opinion in these matters.

The record reflects that the senior advisory council has formulated policy regarding patient charting and shift scheduling that has been adopted by the medical directors. The record reflects that the senior advisory council recommended a charting policy in which physicians would be disciplined for not completing their charts and recommended that the night shift be split into two different shifts. All recommendations made by the senior advisory council are subject to the approval of the medical directors and no actions recommended by this council can be implemented without the consent of the medical directors. Likewise, the record reflects incidents where the senior advisory council made recommendations regarding issues such as meeting times and physician pay that were not adopted by the medical directors.

Another committee upon which emergency physicians participate is the emergency performance improvement committee (EPIC). This committee is made up of Employer, HMO, and hospital representatives who review the practice patterns of emergency physicians. Data regarding medical tests ordered and medical procedures followed by emergency physicians is collected through a computerized tracking program and the data is then analyzed by the committee to determine if a particular physician has a pattern of test ordering that is different from other physicians. When necessary, feedback is given to the particular physician and the physician is instructed by the medical director to reevaluate their protocols. The record does not reflect any instances where the EPIC committee ever formulated any policies or guidelines or that any of its emergency physician members ever made any effective recommendations regarding any of its directives. The record reflects that medical directors are also members of this committee.

The record reflects that emergency physicians at the two Austin hospitals attend the same section meetings. Section meetings typically include emergency physicians, nursing staff, and other employees who work in the emergency room. Physicians from the Burnet and Kerrville hospitals do not attend the Austin section meetings and Austin physicians do not attend the Burnet and Kerrville section meetings. The record reflects that the medical directors and two emergency physicians from Austin occasionally work at the hospitals in Burnet and Kerrville. One of the two physicians is an independent contractor who works for the Employer at Brackenridge Hospital in Austin while the other emergency physician has worked at the hospital in Burnet two or three times. The record reflects no emergency physicians from the hospitals in Kerrville and Burnet work at either of the Austin hospitals.

If an emergency physician leaves employment, the Employer provides emergency physicians at the other hospital sites first priority to fill the vacated position. The record reflects that there is an interchange of patients between Seton Medical Center and Seton Northwest Hospital and both Austin hospitals receive patients from the Burnet and Kerrville hospitals. The record reflects that the Austin hospitals are approximately 10 miles in distance from each other and the hospitals in Burnet and Kerrville are 1 and 2 hours away from these Austin hospitals, respectively.

The record reflects that during the past year, there was an emergency physician who performed scheduling duties for all emergency physicians at the two Austin hospitals. This physician obtained schedule requests from emergency physicians and accommodated as many of these requests as possible through shift allocations. The evidence reflects that the scheduler divided all of the physicians equally among the two Austin hospitals and scheduled them to work the same shifts on a rotating basis. The scheduler did not prepare the schedules for midlevel providers and was paid an extra $100 each hour worked on scheduling and, on average, worked approximately 9 to 10 hours a month in these duties. The Employer has recently hired an employee in its administrative office to handle physician scheduling for the two Austin hospitals.

Supervisory Status of Emergency Physicians

The burden of proving that a certain individual is a supervisor rests squarely on the party asserting that such a status exists. *Vencor Hospital-Los Angeles,* 328 NLRB 1136 (1999); *Youville Heath Care Center, Inc.*, 326 NLRB 495 (1998). In *NLRB v. Health Care & Retirement Corp.*, 511 U.S. 571 (1994), the Supreme Court held that the Board must apply the statutory criteria set forth in Section 2(11) of the Act in the health care field in the same manner as any other industry. The Supreme Court noted that in making a determination on the question of one's supervisory status, the statute requires that three criteria be met: (1) the employee has the authority to engage in one of the 12 listed activities in Section 2(11) of the Act; (2) the employee exercises that authority using independent judgment; and (3) the employee holds authority in the interest of the employer. *Health Care Retirement Corp*, 511 U.S. at 573–574.

Record evidence is clear that these emergency physicians do not have the authority to hire, fire, transfer, suspend, layoff, recall, assign, reward, or discipline midlevel providers. In its brief, the Employer argues emergency physicians responsibly

direct midlevel providers regarding compliance with hospital protocols, standing orders, and Federal requirements regarding the preparation of patient charts. Notwithstanding these arguments, it is well established that restrictions imposed by government regulations do not constitute actual control or supervision by a putative employer. See, e.g., *Air Transit, Inc.*, 271 NLRB 1108 (1984). The evidence reflects that emergency physicians at a respective hospital sign an affidavit pursuant to Texas law that they are responsible for making sure midlevel providers follow hospital protocols and standing orders. Such mandated accountability by the State of Texas does not establish emergency physicians are supervisors. Similarly, the fact emergency physicians are responsible for overseeing that Federal requirements are met in patient chart preparation does not establish their supervisory status.

The evidence reflects that emergency physicians interact with midlevel providers on a routine basis. This interaction includes emergency physicians reviewing patient charts, analyzing X-rays, and generally overseeing that the midlevel provider has provided a patient with adequate medical care. When professionals such as emergency physicians give directions to other employees, those directions do not make those professionals supervisors merely because these professionals used independent judgment in deciding what instructions to give. *Providence Hospital*, 320 NLRB 717, 728 (1996). Such professional direction does not grant emergency physicians supervisory status. *Providence Hospital*, 320 NLRB at 728.

The record demonstrates that interaction between emergency physicians and midlevel providers is limited to the physicians relaying their medical opinions to midlevel providers regarding patient care. The record is devoid of evidence demonstrating that emergency physicians direct midlevel providers regarding their terms and conditions of employment or that they exercise any independent judgment regarding such employment issues. There is no evidence in the record demonstrating that emergency physicians responsibly direct midlevel providers regarding their work schedules, their break and lunch schedules, their office location, or their pay and benefits, or exercise any independent judgment regarding any of these employment areas. See, e.g., *Nymed, Inc.*, 320 NLRB 806, 810–811 (1996); *North General Hospital*, 314 NLRB 14, 17–18 (1994).

In its brief, the Employer references an incident in which emergency physicians made a recommendation to the medical directors that a particular midlevel provider's probationary period be extended past 6 months and an incident where emergency physicians recommended not using another midlevel provider past their respective probationary period. The record reflects, however, that the medical directors, not the emergency physicians, set the dates for probationary periods and that medical directors, not emergency physicians exercise unilateral authority to extend these dates. More importantly, there is no record evidence regarding any details associated with any employee probation or what role the recommendations served in the ultimate decisions made by the medical director.

In its brief, the Employer also references instances where emergency physicians have provided written feedback to the medical directors regarding midlevel providers acting on their own accord. There is no evidence in the record documenting any of these occurrences or establishing that emergency physicians have effectively recommended any particular action be taken in conjunction with these occurrences. *North General Hospital*, 314 NLRB at 17–18. Likewise, the record does not show that emergency physicians have the authority to effectively recommend any action be taken against a midlevel provider for engaging in such conduct. Record evidence demonstrates that such potential disciplinary action remains within the purview of the medical directors and their sole authority to enforce employee handbook policies.

Based on the totality of the evidence, I find that the Employer has failed to show that emergency physicians exercise independent judgment with regard to any of the factors establishing supervisory status under Section 2(11) of the Act, and, as such, I find that these employees are properly included in the appropriate unit.

Supervisory Status of Senior Advisory Council Members

The Employer contends that emergency physicians who are members of the Employer's senior advisory council are supervisors because these employees formulate policies and make effective recommendations to management regarding physician hiring, firing, and retention. The record does not establish, however, that these senior physicians exercise any supervisory authority. First and foremost, record evidence reveals that membership and participation on the senior advisory council does not grant emergency physicians the authority to hire, fire, transfer, suspend, layoff, recall, assign, reward, or discipline midlevel providers or physicians.

In its brief, the Employer argues that senior council members make effective recommendations regarding new physicians hires. Aside from record evidence that senior physicians fill out recommendation forms which assist the medical director in ranking interviewees, there is no evidence regarding what role, if any, these recommendations play in the medical director's ultimate decision to hire or not hire a particular candidate. Likewise, the Employer contends that senior council members vote on whether new physicians should be hired and that the medical director relies on these recommendations. There is no evidence, however, detailing specific instances of where and when this vote has occurred or what role the vote played in the medical director's ultimate decision to hire or not hire an applicant. Mere participation in the hiring process, absent the authority to effective recommend hire, is insufficient to establish 2(11) supervisory authority, *North General Hospital*, 314 NLRB at 16, particularly in light of the fact medical directors retain final decision-making authority associated with any and all employment hiring.

The record references two instances where the senior advisory council recommended that a physician be removed from employment. Notwithstanding these recommendations, the senior advisory council operation guidelines provide that great consideration will be given to senior council members' opinions on physician retention but that the medical directors retain final authority regarding whether a physician is to be retained or not. The retention of such final authority by the medical directors demonstrates that senior council members do not make effective recommendations. *North General Hospital*, 314 NLRB at 17–18. Additionally, the record is devoid of evidence documenting the details associated with the removals or what role the recommendation had with regard to the medical director's ultimate decision to remove the physician from employment.

In its brief, the Employer also asserts that senior physicians make effective recommendations regarding physician evaluations. The evidence shows, however, that the medical director

has final say on the evaluations based on his observations of the physician. The record also reflects that the medical directors seek input regarding physician evaluations from the hospital staff who works with the physician. The Board has held that effective recommendation generally means that recommended action is taken without independent investigation by superiors, not simply that the recommendation is ultimately followed. *Children's Farm Home*, 324 NLRB 61 (1997). The evidence demonstrates that the medical director still conducts and participates in all physician evaluations and that they solicit feedback from sources other than senior council members.

At the hearing, the Employer provided evidence purported to be examples of the senior advisory council formulating policy that was adopted regarding patient charting and shift scheduling. The record reflects that the council recommended a charting policy in which physicians would be disciplined for not completing their charts. The council also recommended the splitting of the night shift. Notwithstanding these two incidents, the record is clear that all recommendations made by the senior advisory council are subject to the approval of the medical directors and that no actions recommended by this council can be implemented without the consent of the medical directors. The record also reflects incidents where the senior advisory council made recommendations regarding other employment issues such as meeting times and physician pay but these recommendations were not adopted by the medical directors. Again, the retention and exercise of decision-making authority by the medical directors demonstrates that senior council members do not make effective recommendations. *North General Hospital*, 314 NLRB at 17–18.

Based on the totality of the evidence, I find that the Employer had failed to show that emergency physicians on the senior advisory council exercise independent judgment with regard to any of the factors establishing supervisory status under Section 2(11) of the Act and, as such, I find that these employees are properly included in the appropriate unit.

Managerial Status of Senior Advisory Council and EPIC Committee Physicians

Managerial employees are defined as those employees who "formulate and effectuate management policies by expressing and making operative decisions of their employer." *NLRB v. Yeshiva University*, 100 U.S. 672, 682–683 (1980). Managerial employees must be aligned with management and must exercise discretion within, or independently of, established employer policy. *NLRB v. Yeshiva University*, 100 U.S. at 682–683. The record reveals that although senior council members have discussed employment policy and made recommendations to management in areas associated with patient charting, work shifts, and physician retention, all recommendations made by these physicians are subject to approval by the medical directors. No actions recommended by the senior advisory council can be implemented without the consent of the medical directors.

In its brief, the Employer argues that emergency physicians who participate on behalf of the Employer on the EPIC committee are managers as defined by the Act. There is no record evidence, however, reflecting any instances where the EPIC committee formulated any policies or guidelines on behalf of the Employer or that any of its emergency physician members ever made any effective recommendations regarding such directives. As such, the evidence is clear that emergency physicians on the senior advisory council and the EPIC committee do not formulate and effectuate management policies of the Employer independent of established Employer policies. Accordingly, I find the senior employees who participate on either the senior advisory council or the EPIC committee are not managers under the Act and are properly included in the appropriate unit. See, e.g., *Montefiore Hospital & Medical Center*, 261 NLRB 569 (1982).

Supervisory Status of the Scheduler

The employer contends that the emergency physician who has scheduling duties for the two Austin hospitals exercises independent judgment and discretion in performing these duties and is thus a supervisor as defined by Section 2(11) of the Act. Notwithstanding this assertion, the record reflects the Employer has replaced this emergency physician with an employee at its administrative office and that this administrative employee, not the emergency physician, handles physician scheduling for the two Austin hospitals. Even if the emergency physician was continuing to perform these scheduling duties, the evidence does not support finding these scheduling responsibilities equate to the scheduler possessing any supervisory indicia.

The evidence shows that the scheduler essentially obtains specific schedule requests from emergency physicians and then tries to accommodate all of these requests through equitable shift allocations. The evidence further reflects that physicians are equally divided among the two Austin hospitals and work the same shifts on a rotational basis. Balancing work assignments among physicians or using other equitable methods does not require the exercise of supervisory independent judgment. *Providence Hospital*, 320 NLRB at 732; *Ohio Masonic Home*, 295 NLRB 390, 395 (1989). Such assignments are considered routine assignments. *Providence Hospital*, 320 NLRB at 727; *Ohio Masonic Home*, 295 NLRB at 395.

Accordingly, the record evidence demonstrates that the employee who performs the duties of a scheduler does not exercise supervisory independent judgment and, as such, I find the employee who performs these duties is not a supervisor under the Act and is properly included in the appropriate unit.